NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

REQUEST FOR PRIOR MEDICAL ASSISTANCE

Medicaid assistance may be requested for up to three months prior to the month of application for public assistance. The client must be eligible in and have proof that medical care or services were provided in the month(s) coverage is requested.

COMPLETE THE FOLLOWING INFORMATION FOR THE PERSON MEDICAID IS REQUESTED FOR:

1. Name: _____ Case No.: _____

2. Home Address: _____ Telephone: _____

3. If you are applying for another person, give YOUR name, address, phone number and relationship: _____

   _____

   _____

4. List all months prior to your assistance application Medicaid is requested for: _____

   _____

5. Proof that medical care or services has been provided during the months requested must be submitted to this office by: _____

6. Applicant's Signature: _____ Date: _____

7. Representative's Signature: _____ Date: _____

   (Use if the applicant cannot read or write or is blind.) I have heard the information contained in this application read to the applicant and have witnessed the signature above.

8. WITNESS:

   Signature: _____

   Address: _____

   Date: _____

9. Case Manager's Signature: _____ Date: _____